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Letter to the Editor

An Islamic cultural perspective of family presence during resuscitation

To the editor

Cardiac arrest followed by cardiopulmonary resuscitation (CPR) is a stressful situation that is frequently faced by healthcare providers (HCPs) and patient's family. During CPR, nurses are challenged by a controversy of either allowing the family members to attend the resuscitation or to leave the room.

Literature about HCPs' positions regarding family presence during resuscitation (FPDR) is inconsistent and ambiguous. Healthcare professionals are generally less supportive of FPDR than patients' families, and levels of support vary by geographic region and culture".[1, p. 533] Tíscar-González et al.,[2] asserted that CPR with FPDR is influenced by socio-cultural contexts, as a uniquely individual case within its context.

In the Middle East, and within a contextual and cultural reference, we argue that the extended family engagement and the strong family ties are factors that impede family members to stay dispassionate during a CPR. Accordingly, most HCPs in this region dismiss FPDR as an option in claim of protecting patients' privacy and avoiding adverse emotional effects on the family.[3]

In a collective societal structure as in the Arabic Islamic culture, family members usually support each other in times of leisure and in times of grief.[4] In Islam, visiting a patient has a religious value. In the context of critical illness and dying, it is a religious duty that a close family member stay at the patient's bedside to prompt the dying patient to recite the "Shahadah" by saying "La Ilaha Illa'llah" (God is the only Allah). It is commonplace to see a kin sitting besides a dying patient reciting verses from the Qur'an or playing an audio of the holy book of Islam. Rituals of spirituality like these make it easier for the family to perceive CPR as imminent, peaceful, and comforting.

Recommendations for introducing FPDR

Permitting or prohibiting family members from attending CPR should be justified and based on evidence rather than on personal judgment. Healthcare institutions should assess patients' and families' needs and preferences by maintaining open communication with patients and their families.

Recommendations to address FPDR implemetation: educating HCPs about FPDR; creating an environment of privacy and communication; considering patients' preferences; having a family liaison; assessing the cultural and religious beliefs of patients and families[5]; initiating a multidisciplinary collaboration[6]; and developing a culturally accepted policy.

Assessing the attitudes and cultural beliefs of HCPs, and providing them with the appropriate training and emotional councelling is another cornerstone. Training may include assessment of transcultural competence, emotional preparedness, and arrangements that help family members get prepared for what they will witness.

In cases of anticipated CPR, HCPs should assess the expectations, perceptions, values, and beliefs of the family members regarding attending CPR. One staff member should stay with family to console them, give support, and allow those who are willing to attend. Allowing a family member to witness CPR provides a successful way of communicating the event to other family members.[7] When a patient survives CPR, the family witness will relay the heroic performance of HCPs to the patient and the family.

Conflict of interest

None declared.

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